Review of compliance

The Royal Wolverhampton NHS Trust The Royal Wolverhampton NHS Trust	
Region:	West Midlands
Location address:	New Cross Hospital Wednesfield Road Wolverhampton West Midlands WV10 0QP
Type of service:	Acute services with overnight beds Community healthcare service Diagnostic and/or screening service Urgent care services
Date of Publication:	August 2012
Overview of the service:	New Cross Hospital is a large acute general hospital and is a location of The Royal Wolverhampton Hospitals NHS Trust. It provides a range of hospital services including planned and

	emergency medical and surgical treatment and maternity services.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The Royal Wolverhampton NHS Trust was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 25 July 2012, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

This inspection was carried out because there had been a number of never events at this hospital trust since May 2011. Never events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented. A number of these related to events in theatres which is where we focused our inspection visit.

The inspection took place on 25 July 2012 and was unannounced. We were accompanied by a professional clinical advisor from the Care Quality Commission to carry out this inspection. Our visit consisted of speaking with staff, looking at policies and procedures, records and observing theatre practice. During this inspection we visited all main theatre areas, and other non-theatre areas where surgical procedures took place.

We spoke with staff who covered a range of different roles within theatres. This included medical and nursing staff who had specific responsibilities in ensuring that any surgery was completed safely. We also met with the medical director, a clinical director, a divisional medical director and the chief nurse as part of this inspection.

We did not speak with many people during this inspection because we were reviewing practice in the operating theatres. We observed staff treating people with dignity and respect. We also saw that people were put at ease and staff were observed to be kind and caring, offering reassurance at all times.

We found improvements were needed in how the trust was monitoring surgical practice in theatres. The completion of surgical safety checks has been accepted in the NHS as good practice in support of the prevention of avoidable errors and omissions in surgical care. We observed procedures where the required safety checks were fully completed by theatre staff as a team. In other procedures, some important checks were either missed or not completed with the full involvement of all members of the theatre team.

What we found about the standards we reviewed and how well The Royal Wolverhampton NHS Trust was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was not meeting this standard. Patients were at increased risk of harm because safe surgical practice was not being followed in all theatre areas. We judged that this had a moderate impact on people who use the service.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was not meeting this standard. The trust did not always review the right things, at the right time, to manage the risk of poor surgical safety practice. We judged that this had a minor impact on people who use the service.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
Care and treatment was not always delivered in all theatres in a way that ensured people's safety. The 'Surgical Safety Checklist' was implemented by the World Health Organisation to use in any operating theatre environment. It was implemented to improve the safety of surgery by reducing deaths and complications. The trust uses adapted versions of this checklist. The trust's surgical safety checklist consists of five different safety checks, completed at various stages of a person's journey through theatre. These are known as team brief, sign in, time out, sign and out and team de-brief.

At the time of our visit, there was no clear guidance in place setting out expected practice in theatres and use of the five steps to safe surgery for all surgical procedures. The majority of staff had a good understanding of what never events were and why the completion of the surgical safety checklist was important.

During our inspection, we observed practice in over 20 surgical procedures, at different stages of the safety surgical check process across all the theatre areas. We saw examples where guidance was followed and surgical safety checks were formally completed as a team, but this was not consistent across all areas.

A 'sign in' check should be performed as part of the admission process to theatre and before the anaesthetic is given to the patient. These checks should be clear, formal and read out loud. We were told by one member of staff that the check had been completed

on the ward without other members of the theatre team, including the anaesthetist, being present. We saw another example where the patient was not asked directly about their consent, their identity or their understanding of the procedure. This check was not read out loud and we saw that two of the staff were talking with each other and were not listening to the check. During another observation, we saw a staff member join the check approximately half way through. They answered one of the questions but then left the room prior to the check being completed. We saw some good examples where staff stopped the check and repeated the question because staff were talking and not paying attention.

Just before an operation commences, a 'time out' check should be conducted, where staff make sure the next stage of the checklist is completed. Staff told us that these checks were always done but we saw on one occasion that this check was not completed. During another check, we observed staff talking to each other and not paying attention to the person leading the check. We saw some good examples of the 'time out' check being performed. The check was done efficiently and quickly, and included the information on the hospital checklist. Staff were quiet and attentive during this time which meant that everyone was actively engaged in the process.

Following the surgery a 'sign out' check should be performed before any member of the operating team leaves theatre. This check should also be a designated and structured quiet time. We observed a number of these checks. We saw examples where the check was very structured, and on a couple of occasions the check was stopped because not all staff were in the theatre area. The staff member leading the check said they never commenced a check without all staff being present because it minimised the risk to the patient. We saw that checks were done on the swabs and equipment. We observed other sign out checks where the surgeon continued to perform surgery on the patient during this check.

The inconsistent practices we observed across all theatres meant that there was an increased risk of harm to people during surgery because some important checks were either missed or not completed with the full involvement of all members of the theatre team.

Other evidence
There was no other information to report at the time of this inspection.

Our judgement
The provider was not meeting this standard. Patients were at increased risk of harm because safe surgical practice was not being followed in all theatre areas. We judged that this had a moderate impact on people who use the service.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
All of the staff we spoke with were aware of the need to report incidents and said they felt confident to report to the senior person on duty. We were told that following a never event the trust undertook an investigation. We reviewed examples of recent investigations that the trust undertook following a never event, which were detailed and set out clear actions to be taken.

The way the trust shares information with staff had started to improve. Staff told us that historically they were only aware of incidents that occurred in theatre areas where they worked. They told us that more recently, they were made aware of incidents in other areas and knew about wider actions taken by the trust. A trust newsletter had been published on the lessons learnt from incidents including never events and we heard that there were plans for this to be published quarterly. Whilst in theatre areas, we saw posters identifying the range of never events. We also saw that the monthly checklist audit completed was on display on notice boards in different theatre areas.

We heard from senior managers within the trust that the organisation had been slow to pick up trust wide learning following never event incidents but that key learning had started to take place. For example, they held a trust wide briefing on never events in June 2012. Each directorate has their own monthly meetings and never events were being discussed. Information from these meetings was cascaded to a 'lead' person across service areas, who were responsible for sharing this information.

There was evidence that learning from incidents took place and appropriate changes were implemented. One staff member described how they had seen changes in how their department worked since they had experienced never events in their own theatres. We were told that as a result, the experience had brought the team together and both nursing and medical leadership was considered to be strong. However, we spoke with a member of theatre staff in this department who did not know what a never event was. In another department a senior member of staff was unable to recall specific information about the last never event. We noted that one of the lessons learnt from the trust's own investigation into a never event from March 2012 identified that mistakes will occur if there are distractions. Our observations in theatres did not reflect that learning from this incident had been embedded across all theatres.

Senior managers from within the trust had identified their expectations in relation to reporting and monitoring the completion of surgical safety checks on a daily basis. However we found different practices in different theatres. For example, in some theatres it was monitored daily, in others weekly. Information from these audits was used to produce an overall monthly compliance report which focussed on the completion of the supporting checklist. These audits did not monitor whether all five stages of the checks were completed as a team. We saw that there was space on the team brief and de-brief forms for staff to identify what challenges they faced when completing the audit. We were told by a matron that staff were "getting better" at completing this section. The matron told us that if there was information of concern noted on this form, it would be raised with the relevant head of department.

We looked at the last trust compliance report which was submitted to the trust's quality and safety committee in June 2012. This report identified that modified checklists had been implemented in some of the non-theatre areas. However we spoke with staff and found these had not been fully implemented in these areas at the time of our visit.

Senior managers within the trust considered that safe surgical practice was led by medical staff. The findings from our visit were that in some areas, this remained a nurse led process. The trust told us that all theatre staff had received training and education in safe surgical procedures but there was limited information to support how this was being shared with new medical and nursing staff. We were made aware during our discussions with the local primary care trust that a further programme of theatre team training and development was being organised.

We were told that risk assessments were being completed across all departments to identify and manage the potential for never events. We found that action had been taken to address individual staff performance issues where never events had occurred. At the time of our visit there had not been a never event since May 2012.

Other evidence
There was no other information to report at the time of this inspection.

Our judgement
The provider was not meeting this standard. The trust did not always review the right things, at the right time, to manage the risk of poor surgical safety practice. We judged that this had a minor impact on people who use the service.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Important safety check-lists were not always effectively completed in some of the operating theatres at The Royal Wolverhampton Hospitals NHS Trust. Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010	
Surgical procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: Gaps in monitoring systems meant that the completion of the checks as a team was not being audited regularly and that learning from incidents had not been fully embedded across all theatres. Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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